Q&A

FROM OUR PERSECTIVE:

COVID – 19: ACHIEVING STRATEGIC AND OPERATIONAL SUCCESS

We are facing one of the most significant healthcare challenges in our lifetime. Our clients and other hospitals around the nation are searching for more capacity: space, beds, equipment, and providers to prepare for a potential surge in COVID-19 cases. The political debate around our healthcare delivery and insurance model has taken a backseat to the tactical realities of today.

Our experts come at this problem from two distinct vantage points: consultants and operators with extraordinary healthcare experience as well as our COO, an Army General, who has led troops into combat and understands leading people under difficult conditions.

Here is a recent Q&A session with our team:

Q: What actions do you see your clients taking right now and how are you advising them?

MITCH GALLOWAY, Galloway CEO: Based on what I am reading and hearing from folks who we have contacted, our clients are implementing their disaster plans that they have designed for mass casualty or pandemic events – no elective surgery, triage outside the hospital, redeploy staffing to areas of need, etc. So right now, there is a heightened sense of urgency of course but most feel like, for now, they have it in hand. That could change in a couple of weeks depending on whether we "flatten the curve".

BRUE CHANDLER, former Hospital CEO. The biggest problem for all but the most progressive C suites will be that the organization becomes so caught up in the moment, they will fail to maintain focus on other goals and initiatives. It's exhausting but exciting to be in the planning meetings for the crises and take advantage of what seems to be new sources of money from a more liberal use of capital to spend. After the crisis plans are in place, the progressive CEO will focus key people on the crisis and most of the others on the routine of doing well by each patient, completing projects and adjusting to budget.

MITCH GALLOWAY. I like Brue's point. How long can they let the emergency response squeeze out the strategically important stuff one really needs to be doing? But it is definitely a Maslow hierarchy thing. I imagine that Brue's message will resonate more in a couple of weeks.

BRUE CHANDLER: It will be a hard to do for many, who will get bogged down in the swamp with the staff. A key time for leadership.

Q: Speaking of leadership, you've seen a lot of crisis type situations, both in the Army and out. What advice to you have for leaders in hospitals?

BOE YOUNG, Army Major General (Retired): There are three key lessons that I think apply to hospitals leaders in this situation:

First, recommit yourself to full transparency in decision making and business results – flat communication builds trust, even when the news is bad. Without frequent updates – more frequent than you would under normal business conditions – employees will extrapolate "no news" to mean "bad news" and they assume the actual results

are worse than reality. Remind your team that at times, the truth changes, and with constant assessment and feedback you are likely to increase the focus employees have on the key tasks at hand. With COVID-19, I think most people realize that each day brings a new set of circumstances.

Second, stay laser focused on the top two or three things that are critical for organization's success today. Your personal attention is required in order to understand the problems and ensure enough focus and resources are being applied to the root causes of the problem.

Third, you still have a business to run…the most difficult task to master is to remain focused on the strategic elements of your "regular" job – as well as those top two or three crisis tasks mentioned above. Staying engaged on the strategic priorities that drive your business and balancing the second and third points is what will differentiate great leadership from average.

Where specifically do you see our clients needing to focus?

LARRY SESTON, Galloway EVP: We are hearing about seven or eight main areas:

- Supply Chain – this includes tracking down incremental and probably scarce supplies specific to caring for these patients. There is much additional work here to seek alternate vendors, track orders, warehouse and distribute to avoid stock outs, etc.

- Increasing specialty physician capacity – With about 12,000 pulmonologists in the US – and only a handful in some states - I would imagine the pulmonologists could be over capacity in an instant. We should be looking at how we can we build protocols to allow Respiratory Care to supplement, for example.

- Clinical Staff Shortages – ICU's will quickly be overwhelmed, and staff will burn out quickly and of course, be subject to infection. Locating staff to supplement and trying to manage the capacity of specialties across geography, will be critical. This will extend beyond nursing to RC, Pharmacy, EVS, etc.

- Patient flow – Changes to patient flow will be needed to diagnose incoming patients away from the main area such as ED.

- Patient Aggregation – To the extent possible, consider creating a COVID-19 hospital within a hospital, designing processes around that population while disrupting the care of other patients as little as possible.

- Facility capacity – ICU space will need to be expanded either by converting existing units or standing up temporary structures.

- Ancillary Services – All services and departments will need to modify standard process to remain compliant with isolation needs.

- Communication – Patient families will need considerable information about loved ones especially since they will often not be able to see them or touch them. Most of our clients have relatively limited personnel in these areas.

SHEILA McNULTY, Nurse Executive: In addition to staffing shortages there may be a need to alter the staffing model and staff schedules from an employee and patient perspective. Regarding surge capacity, systems may look across the enterprise for alternative locations to respond to an influx of patients. Some communities might be looking for a coordinated regional plan to offload or care for the community at large if the numbers of sick increase.

PATTI McCUE, Galloway CNO: I especially like Larry's comment about communication. Hospitals here in Virginia are either not allowing visitors at all or restricting to one family member with limited visitation time. Communication is definitely going to more of an issue going forward.

LARRY SESTON: We see a lot of promise in hospitals that take the time now, to ensure their patient flow processes are streamlined. A few

days of work on the front end now, could increase capacity by thousands of patients, once full-scale testing kicks in.

Final thoughts, at least for today?

BOE YOUNG Don't assume your standard Emergency Operations Center construct will work, at least for the long term. First, many EOCs are designed for operating for days at a time, not months. You must establish an operating rhythm designed for the long-haul. Second, your structure must be agile and willing to change daily, as you see the community needs evolve. Finally, pay attention to decision rights and accountability. Your leaders in the EOC must be empowered to make decisions in a way that helps them "make the news", not just "report the news".

MITCH GALLOWAY: If we really do flatten the curve, hospitals will be living with this for a long time and won't be able to pause everything else for 4-6 months. CEOs must be able to navigate the tactical and the strategic successfully. But first things first, let's make sure that we have the resources and processes in place to take care of this crisis.

ABOUT GALLOWAY CONSULTING AND OUR EXPERTS

Galloway Consulting helps hospital groups, physicians, and payer/providers improve operations, outcomes and profits so they can better serve their communities. Our healthcare team has mastered every aspect of the business.

Mitchell Galloway is the CEO and co-founder of Galloway Consulting and built his reputation by helping healthcare executives transform their organizations, often achieving landmark results on seemingly impossible timetables. He has an MBA from Emory University's Goizueta Business School, where he achieved the #1 class ranking and has a Bachelor of Science in Health Systems from the Georgia Institute of Technology.

Boe Young is the Chief Operating Officer of Galloway and has personally led new CEO/senior executive transitions in five private and public-sector organizations. He was a Major General in the US Army Reserve has commanded a battalion in combat, has two master's Degrees, including an MBA from Goizueta Business School at Emory University, and over 25 years of senior executive profit and loss experience.

Brue Chandler has over 40 years of experience in large, complex organizations. Mr. Chandler has served as the President, COO, or Chief Administrative Officer or in five complex hospitals, displaying unique leadership talents and competency across multiple dimensions and markets. Mr. Chandler has a Masters in Hospital Administration from Georgia State University and a Bachelor of Industrial and Systems Engineering from Georgia Tech.

Sheila McNulty brings broad operational, strategic, and clinical healthcare experience across the spectrum of inpatient and outpatient services areas. Sheila's expertise includes nursing, clinical operations, acute care operations, capacity management, operational improvement, care progression/care coordination, workforce management, and service line management. Ms. McNulty has worked as a healthcare consultant for GE, a COO of a community hospital and as CNO is a large hospital that was part of a major regional system. She has a Masters of Healthcare Administration from the University of North Carolina Chapel Hill and a Bachelor of Science of Nursing from UNC Charlotte.

Patti McCue is Galloway's Chief Nursing Executive and is credited with designing and introducing innovative professional development programs to take nursing departments to the next level. Dr. McCue's expertise spans integrated healthcare systems, an academic medical center, the largest rural hospital in the country, and nonprofit teaching hospitals. Patti has a Doctor of Science in Health Science from Tulane University, a Masters in Nursing Administration from the Medical University of South Carolina and a BA in Nursing from the same institution.

Larry Seston. Mr. Seston is Partner and Executive Vice President and leads Galloway's most complicated performance improvement projects. He was the team leader for two of the most dramatic healthcare turnarounds in the country along with dozens of other similar engagements over the past 16 years with Galloway. He has an MBA from Southern Illinois and a BS from Wisconsin.